Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JEREMIAH TWOMEY

Respondent Name
HARTFORD INSURANCE COMPANY OF

MFDR Tracking Number
M4-14-2058-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "a position statement of the disputed issue(s) that shall include:

(i) a description of the health care for which payment is in dispute,

DESIGNATED DOCTOR EXAM

(ii) the requestor's reasoning for why the dispute fees should be paid or refunded,

CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement for the above date of service was processed in accordance with Rule 134.204.

Reimbursement for CPT 99456 W5,WP was processed as follow:

MMI - $350.00

IR-Ankle $300.00

IR Back & Ir Rib - $150.00 – these (2) site would fall under the same musculoskeletal body area as defined under Rule 134.204 (j)(4)(C)"

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 06, 2013	Maximum Medical Improvement and Impairment Rating Examination	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W1 – Workers Compensation State Fee Schedule Adjustment
    - 309 –The charge for this procedure exceeds the fee schedule allowance
    - W3 – Additional payment made on appeal/reconsideration
    - 193 – Original payment decision is being maintained. This claim was processed properly the first time
    - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance

Issues

1. What is the applicable rule for the disputed services performed?
2. What is the allowable reimbursement for the impairment rating of the body area performed?
3. Is the requestor entitled to reimbursement?

Findings

1. The dispute is in regards to a Designated Doctor Impairment Rating (IR) evaluation of the spine and lower extremity with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states "The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area."
2. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(-a-)(-b-), the requestor, in this case, was required to perform a full physical evaluation with range of motion to the spine and lower extremity. Review of submitted documentation finds that the spine and lower extremity was rated using a full physical evaluation with range of motion. The Division concludes that the impairment rating of the spine is allowed at $300 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-) and lower extremity allowable is $150.00 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-b-).
3. The division concludes that the total allowable for the impairment rating of the spine and lower extremity is $450.00.The respondent issued payment in the amount of $450.00 for the Impairment Rating (IR) of the spine and lower extremity. Based upon the documentation submitted no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/31/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.